ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE

Location of Meeting
Frontier Building, 3601 C Street, Room 880/890

MINUTES OF MEETING
May 20, 2005
8:00 a.m.
As approved September 16, 2005

Committee Members Present:

Marvin Bergeson, MD
Michael Boothe, DDS (late arrival)
Amber Briggs, PharmD
Heidi Brainerd, MS, RPh
Richard E. Brodsky, MD
Jeffrey G. Demain, MD
Traci Gale, RPh (telephonic)
Vincent Greear, RPh
R. Duane Hopson, MD
Thomas K. Hunt, MD
Ronald Keller, MD
Diane Liljegren, MD (telephonic)
Andrej Maciejewski, MD
Ronald J. Miller, RPh (telephonic)
Gregory R. Polston, MD (late arrival)
Janice L. Stables, MSN, ANP
George Stransky, MD
Alexander H. vonHafften, MD
Trish D. White, RPh

Committee Members Absent:

Robert Carlson, MD
Kelly Conright, MD
Ronald Keller, MD
Andrej Maciewjewski, MD
Sherrie Richey, MD

Others Present:

David Campana, RPh
First Health Representatives:
Mary Roberts, RPh
Melinda Sater, PharmD

I. CALL TO ORDER:

Chairman Brodsky called the meeting to order at 8:00 a.m.

II. ROLL CALL:

The roll call was taken and a quorum was present. New members were introduced:

III. PUBLIC COMMENTS FROM LOCAL PHYSICIANS:

There were no public comments at this time.

IV. PRESENTATION ON BEHAVIORAL PHARMACY MANAGEMENT SYSTEM (BPMS)

Public Comments: No public comments for this item.

Presentation: Bruce Gorman, MCRP, and Sandra Forquor, Ph.D., showed a Power Point presentation to the committee about their company, Comprehensive NeuroScience (CNS), and the proposed BPMS system. CNS was founded in 1999 and specializes in pharmaceutical clinical research, education and managed prescribing in neuropharmacology. They have clinical trials, expert knowledge systems, and behavioral pharmacy management divisions. Their goals are to improve the quality of behavioral health prescribing practices, improve patient adherence and reduce spending on Medicaid behavioral drugs.

The process began with an orientation letter, sent to all providers who prescribed behavioral health drugs in the past year. A small subset will be selected to receive monthly mailings (approximately 275-300 providers). A selected 100 providers will be given the opportunity to receive important information about prescribing. CNS will work with Medicaid, Dr. Hopson and others to write custom cover letters each month.

CNS prepares several types of educational reports. A clinical practices statement will accompany reports and educational briefs and are written for all levels of prescribers. These will include specific FDA dosing guidelines. A prescriber summary report will give providers a snapshot of practice patterns and report prescribing patterns that vary from best practices. A patient detail report gives information about specific patients and their profile in relation to the goals of best practices. Educational briefs give detailed information to providers and are updated regularly.

The BPMS feedback process allows prescribers to give comments in response to missives sent by BPMS and they can offer clinical comments or request peer consultation. A steering committee is comprised of psychiatrists, primary care providers, pharmacists, APRN and state officials.

In summary, BPMS is a quality improvement tool with changes in inappropriate practices indicated at six months. New prescribers and patients will continuously be added and program progress will be reported to the P&T Committee regularly.

P&T Committee Discussion: Dr. Polston asked about the categories to be reviewed. CNS responded that among those reviewed are anti-psychotics, antidepressants, and stimulants will be included. Further information and a detailed list can be provided to the committee. There are over 130 medications reviewed monthly.

Dr. vonHafften asked if opioids will be included. CNS responded that there is a list of 60 opiates, and they will offer to the steering committee the option of including those. There is a new series of quality indicators that includes opiates, and it will be presented at the clinical users meeting in Atlanta. They will then relay their decision to the Alaska committee.

Dr. Demain asked who funded CNS. CNS responded that Eli-Lily provides their funding, but there is a system in place to protect CNS from undue influence. There is a three-way agreement between CNS, State of Alaska and Eli-Lily with a strong firewall. Eli-Lily cannot influence educational edits.

Dr. Brodsky asked about the response to the community meeting in Alaska. CNS responded that there were several presentations and opportunities for comment. There is some concern, as the first reaction is often defensive, but mostly the emphasis was on quality. The first comments have been positive and the responses to the initial mailing will be reviewed soon.

Dr. Hunt asked about data from other states that this alters prescribing patterns. CNS will provide data about prescribing patterns. There was a study done in Missouri which showed the relationship between patients and prescribers. There has been a significant impact in Missouri and reduced costs due to prescription changes. Executive management reports track changes and look at the results of CNS. Dr. Hunt mentioned this is activity best suited for the drug utilization committee. Mr. Campana said this is for P&T committee information as this is another initiative in the Medicaid program. Dr. Hunt stated if this system could be implemented for opiates, it would do a tremendous favor.

Dr. vonHafften asked if CNS has been approached by other industry sponsors to assist in sponsoring this kind of a program in other states. CNS responded that Bristol-Meyers Squibb is the funder in one state, and Astra Zenica is the funder in another state. Florida has five companies working together for funding.

Dr. vonHafften commented that the BPMS system is not a formulary, and it is not a fail-first or restrictive algorithm. It provides quality of care, education and improved feedback. It does not cost the State a lot of money during the two year pilot period. It is an opportunity to try to improve the quality of care. Dr. vonHafften expressed his hope that this will dovetail with access to other services that improve the overall quality of care including future discussions about alcohol/drug treatment and safe housing for people with persistent psychiatric illnesses.

The committee thanked CNS for the presentation.

V. RE-REVIEW ANTIHERPES VIRUS AGENTS

Public Comments:

Roy Howard, PA-C, commented on antivirals. There are three main drugs used, and the one with the most indications is Valtrex. He is concerned about pressure from other review agencies to write for acyclovir, but when this a drug requires five times a day dosing, compliance is difficult. He asked that the committee consider compliance in their decision making.

P&T Committee Discussion:

Ms. Roberts of First Health presented information about this class. There are three products available at market, and all three are FDA approved for genital herpes, acute and suppression therapy. There are additional indications that vary by agent. Acyclovir is the only one indicated for chickenpox. Alaska has all three agents preferred currently. At last discussion, acyclovir was included due to its pediatric and chickenpox indications.

Dr. Brodsky asked about the market data, and Ms. Roberts reported 100% compliance with all three agents preferred. In March 2005, Famvir was at 14%, Valtrex 45% and acyclovir at 42%.

DR. STRANSKY MOVED TO KEEP RECOMMENDATIONS THE SAME AS LAST YEAR – ALL ARE EQUIVALENT BUT KEEP ACYCLOVIR DUE TO PEDIATRIC INDICATIONS. SECONDED BY DR. BERGESON. CHAIRMAN BRODSKY CALLED FOR DISCUSSION ON THE MOTION, AND AFTER BRIEF CLARIFICATIONS, HE CALLED FOR A VOTE. THE MOTION WAS APPROVED UNANIMOUSLY.

VI. RE-REVIEW ANTIFUNGALS

Public Comments:

Andrew Weis, PharmD, from Novartis discussed Lamisil for onychomycosis treatment. Prior to initiation of therapy, nail specimens for lab testing need fungal biopsy to confirm diagnosis. Efficacy is reported in patients with toenail or fingernail infections in three studies in the US and Canada. Mr. Weis gave information from medical journals about Lamisil, stating Lamisil was preferred over Sporanox after metaanalysis of the available studies.

P&T Committee Discussion

Ms. Roberts presented information on this class. There are three products available in this category: griseofulvin products, Lamisil and Sporanox; all three are FDA approved. At last review, the committee consulted a pediatrician, who felt griseofulvin was important in the pediatric population. Infectious disease physicians reported preferring Lamisil due to safety issues. The P&T Committee voted to approve Lamisil and griseofulvin. Current prescribing data shows PDL compliance is 81%, but it is higher because Pen-Lac is topical and not included for PDL purposes. Vast majority goes to Lamisil.

Dr. Hunt asked why, if Medicaid pays for Pen-Lac, it is not reviewed by the committee. Ms. Roberts and Mr. Campana stated that the main reason is that it is a different product. Dr. Demain stated it was not very efficacious, so why pay for it. Mr. Campana responded that it is required by law and the DUR will review it. Ms. Briggs noted that some patients cannot take oral products. Ms. Roberts stated that out of 130 claims for the month, 21 were for Pen-Lac. Dr. Hunt stated it is unreasonable to pay for these drugs and suggested they not be preferred. Dr. Liljegren asked why any were preferred, as providers can use "medically necessary" for those rare patients that need these products. Mr. Campana said

the DUR could review this class to limit their use. Dr. Demain pointed out that these drugs have off-label uses also, but the committee cannot review off-label uses. Dr. Bergeson noted that griseofulvin products are used for tinea capitis in pediatric populations. Dr. Liljegren suggested using "medically necessary" for these indications. Dr. Demain asked if there was a cost benefit to allowing these on the formulary and that this be considered. Dr. Liljegren said it makes it easier to save the state money if these are not on the preferred list, as she can explain it more clearly to patients that most uses of this class are cosmetic. Dr. Demain gave examples of how it can be cost effective to keep them on the list. Dr. Brodsky stated that if it is not approved, there are no cost breaks. Ms. Roberts said if there is a clinical edit, there can be a preferred agent, but this is done by DUR.

Dr. Boothe, Dr. Miller, joined the meeting at this point. Dr. Brodsky called for a motion.

DR. HUNT MOVED THAT GRISEOFULVIN AND TERBINAFINE BE PREFERRED AND THE DUR DO PRESCRIBER EDUCATION ABOUT THE OPTIONS. SECONDED BY DR. DEMAIN. DR. BRODSKY CALLED FOR DISCUSSION. AFTER MINIMAL DISCUSSION ABOUT THE DEFINITION OF PEDIATRIC DESIGNATION REQUIREMENTS, DR. BRODSKY ASKED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

VII. RE-REVIEW OF ORAL CEPHALOSPORINS (SECOND GENERATION)

***Public Comments*:**

There were no public comments on this class.

P&T Committee Discussion:

Ms. Roberts provided information about the four available agents, all with similar indications. At last review, the infectious disease specialist indicated no preference. Comments from a pediatrician and a pulmonologist indicated preference for Ceftin or Cefzil. P&T unanimously agreed to include Ceftin suspension, cefuroxime tablets, and Cefzil tablets and suspension currently preferred. Current compliance is 98%. Ceclor and Lorabid were not preferred.

Dr. Bergeson pointed out that Suprax is back on the market as a suspension, and it is the best tasting of all of them with other positive benefits. Dr. Demain stated that Cefzil was on there before because Ceftin suspension tasted so bad. Dr. Demain asked that Suprax be included. Ms. Briggs pointed out that Suprax is a 3rd generation.

Dr. Hunt asked why the committee preferred Ceftin tablets, and Ms. Roberts responded that they are available generically. The committee felt they were equivalent last time, liking Cefzil for flavor. There is nothing in prior notes indicating discussion about Ceclor or Lorabid, and Ms. Roberts assumed the committee did not feel it necessary. Dr. Demain stated he is amazed that cefaclor is still on the market with its erythema side effect. Ms. Roberts reported Ceclor is not preferred in South Carolina. Dr. Demain further stated that

Lorabid has a limited spectrum making it not an optimal single choice for a second generation.

Dr. Hunt then commented on the content of the packets provided by First Health. He stated that the articles given went back as far as 1988. Ms. Roberts stated that there is not a lot of recent publication in this class and not a lot of activity. She does not know of any publication that attests to the committee's discussion today, but it is what physicians have brought to committees as anecdotal evidence. Dr. Hunt asked about a mechanism for bringing that information, which is more clinically relevant than a drug company-sponsored lab study. Ms. Roberts opined that it is the committee's purpose, with First Health only bringing documentation from literature and not discussion information. There may be liability associated with First Health bringing documentation that is anecdotal in nature. The committee further discussed anecdotal versus documented drug information. Ms. Roberts stated she would bring this back to the First Health review team for their consideration.

DR. DEMAIN MOVED THAT NO CHANGES BE MADE TO THIS CLASS, WITH CEFZIL AND CEFTIN TABLETS CONSIDERED EQUAL AND CEFZIL SUSPENSION PREFERRED. SECONDED BY DR. BERGESON. CHAIRMAN BRODSKY CALLED FOR DISCUSSION ON THE MOTION. AFTER MINIMAL DISCUSSION, DR. BRODSKY CALLED FOR A VOTE. MOTION CARRIED UNANIMOUSLY.

VIII. RE-REVIEW ORAL CEPHALOSPORINS (THIRD GENERATION)

Public Comments:

Nancy Lewis, PharmD, from Purdue Pharma commented on Spectracef. This 3rd generation cephalosporin is stable against common side effects. Indications are for treatment of mild to moderate infections in adults and children above age 12. After providing information about various studies and their conclusions, she asked that the committee consider adding Spectracef.

P&T Committee Discussion:

Ms. Roberts of First Health provided information about this class. There are four agents available with Suprax suspension back on the market, for a total of five agents available. At last discussion, infectious disease specialists indicated no preference of the four. Omnicef, Vantin, Cedax and Spectracef were discussed with a pediatrician stating Omnicef was more palatable over Vantin. Pulmonologists felt all were clinically equivalent. P&T unanimously agreed all were clinically equivalent but wanted Omnicef due to taste. Compliance is 94% with Cedax and Omnicef currently on the list.

DR. BERGESON MOVED THAT THE COMMITTEE CONSIDER THESE THERAPEUTICALLY EQUIVALENT BUT PREFER ONE GOOD TASTING SUSPENSION, EITHER SUPRAX OR OMNICEF. SECONDED BY MS. BRIGGS. CHAIRMAN BRODSKY CALLED FOR DISCUSSION ON THE

MOTION. HEARING NONE, CHAIRMAN BRODSKY CALLED FOR A VOTE. MOTION CARRIED UNANIMOUSLY.

Off record at 9:25 a.m.
On record at 9:45 a.m.

IX. RE-REVIEW OF ORAL MACROLIDES

Public Comments:
Don Moran from Sanofi Aventis testified about Ketek, an oral treatment for bronchitis, acute bacterial sinusitis, and mild to moderate community acquired pneumonia. This is the first of a new class of compounds, ketalides and this class is a subset of a macrolide group. It resists adaptive mechanisms. Phase III studies show it is equal to antibiotics of first line agents. For community acquired pneumonia, when Ketek was given once a day for seven days, compared to other substances, it was equally effective clinically and bacteriologically to comparative drugs. It has rapid response of two hours peak level with a half life of 10 hours. It has extensive hepatic metabolism, requiring judicious use. 1% of patients have reported blurred and double vision. He asked that this drug be included on the PDL as it has applications to peculiar needs in Alaska.

P&T Committee Discussion

Ms. Briggs asked if Ketek is part of macrolides, or is it to be reviewed by itself. Ms. Roberts stated it would be reviewed with macrolides and provided data on this class. In last year's discussion, Ketek was not included. Preferred agents are azithromycin, Biaxin and Zithromax. Pediatricians and pulmonologists agreed that Zithromax and Biaxin are clinically equivalent, but wanted all three preferred due to unique indications. ID specialists preferred Zithromax for ease of use and tolerance. P&T unanimously agreed to include all three agents. Ketek should be considered also.

Dr. Demain asked about Pertussis treatment with Ketek. Dr. Moran offered to look up that information for the committee. Ms. Briggs pointed out that patients on Lipitor or other cholesterol medications have to stop that while taking Ketek due to interactions. Ms. Roberts stated that it elongates Q/T also. Ms. Briggs asked about resistant patterns for Zithromax, and the committee had no general answer. Dr. Hunt stated there is emerging pneumococcal resistance to azithromycin. Dr. Demain stated he has had good results with Ketek in patients who have already had two to three rounds of antibiotics.

Dr. Brodsky suggested making Ketek medically necessary status. Ms. Roberts stated their niche is for resistance. Dr. Brodsky would like this to be used in limited ways. Dr. Bergeson asked about azithromycin use and Ms. Roberts stated it is 2% of market share is for erythromycin. Azithromycin is at 86%. There are 1785 prescriptions for March. Ms. Brainerd reported there is a lot of erythromycin use in the villages but it is not being billed, so the data is skewed.

MS. STABLES MOVED TO CONSIDER ALL THREE EQUIVALENT INCLUDING AZITHROMYCIN AS GENERIC AND SAVING KETEK AS A

SECOND LINE AGENT. MOTION SECONDED BY DR. STRANSKY. CHAIRMAN BRODSKY CALLED FOR DISCUSSION ON THE MOTION. HEARING NONE, HE CALLED FOR A VOTE. MOTION PASSED UNANIMOUSLY.

X. RE-REVIEW OF QUINOLONES (SECOND GENERATION)

Public comment:
Steve Ichishta, MD, from Schering Plough testified about Cipro XR. This medication is an extended release formula of ciprofloxacin indicated for uncomplicated urinary tract infections. It has rapid bacteria activity and it is recommended as a first line agent, with 20% use locally. It is indicated for UTI and pyelonephritis and is dosed once a day.

P&T Committee Discussion

Ms. Roberts gave information about this class. There are currently four agents available, and the current PDL preference is ciprofloxacin. All are indicated and effective for UTI with specific indications that vary per drug. ID specialists prefer ciprofloxacin.

Dr. Hunt asked if Cipro was preferred or equal. Ms. Roberts answered that the P&T unanimously agreed to prefer ciprofloxacin and include other agents if cost effective; class effect but to include ciprofloxacin. Cipro had 15 claims and Cipro XR had 10. Ms. Stables asked if a pharmacist could comment on ofloxacin for GC and chlamydia. Ms. Roberts answered that 300 mg b.i.d. for 7 days is the usual dosing. Dr. Hunt asked what the state recommended. Dr. Brodsky answered that the state recommended not using quinolones.

The committee continued its discussion about quinolones and their relation to third generation medications. Dr. Brodsky recommended doing like last year which would probably give Cipro and generic ofloxacin, which would be fine. Dr. Hunt stated if the committee keeps it for anti-pseudomonal effect as superior, and this is losing its pseudomonal activity and, then why prefer it. Ms. Roberts stated it has low use and it is safe. Dr. Demain stated that Dr. Roberts prefers Cipro for children, but Ms. Briggs stated it is not indicated for children. Dr. Demain stated it is preferred but not studied.

DR. BERGESON MOVED TO CONSIDER THESE THERAPEUTICALLY EQUAL BUT TO INCLUDE CIPRO. SECONDED BY DR. STRANSKY. DR. BRODSKY CALLED FOR DISCUSSION. HEARING NONE, HE CALLED FOR A VOTE. MOTION PASSED UNANIMOUSLY.

XI. RE-REVIEW OF QUINOLONES "RESPIRATORY" (THIRD GENERATION)

***Public comment*:**
Steve Ichishta, MD, commented on Avelox, which is indicated for community acquired pneumonia, acute sinusitis, acute exacerbation of chronic bronchitis, uncomplicated skin and skin structure infections among other things. It is faster than Levaquin with less

resistance. It is widely available and well tolerated. ID specialists feel it is the best in its class.

Dr. Ann Speiser of Johnson & Johnson testified about Levaquin. It is approved for 11 indications for short-courses. It has better adherence and less resistance. Levaquin is 98% effective in multi-drug resistant infections. It has an exceptional safety profile, dosing flexibility with IV and oral solutions, and helps improve appropriate use of antibiotics. It is more effective against gram positive and gram negative organisms. She asked that Levaquin be considered the best choice as it has the best breadth of action.

P&T Committee Discussion:
Ms. Roberts presented data about this class of drug. Currently there are three available with Tequin, Levaquin and Avelox. Levaquin is the current PDL agent, and at last review the ID specialist felt all agents were similar, but Tequin was better for anaerobes. P&T declared class equivalent and there is 96% compliance with Levaquin.

Dr. Brodsky presented letters from Dr. Buff Burtis, Dr. Geronimo Sahagun, Dr. Jerome List, and Dr. Timothy Skala. Dr. Burtis stated levofloxacin is preferred at Alaska Regional Hospital. Dr. Sahagun supports Levaquin being preferred. Dr. List prefers Levaquin. Dr. Skala preferred Avelox for MRSA infections. Dr. Hunt asked if there was a letter from Dr. Tomera. This letter was not included, but Miri stated he prefers Levaquin.

As for QT prolongation with Tequin, there is concern from various commentors about this. Dr. Demain stated that at a hospital where Tequin was on the formulary for a year; they felt the incidence of cardiac events had increased compared to what they had previously. Dr. Hunt asked about the comments from the VA, as they prefer Tequin. The committee continued its discussion about QT risks with Tequin. Dr. Hunt asked again about more detailed summarized information being provided by First Health to committee members. Ms. Roberts again stated she would bring those concerns to the review team. Ms. Brainerd asked about bringing summary data to the committee. Dr. Hunt reiterated that the QT concern needs to be considered.

Dr. Demain asked if they leave things as is, would that cause Levaquin to be preferred or would it continue the current arrangement. Ms. Roberts suggested the committee make clinical decisions and the State make financial decisions. Ms. Brainerd stated that if the committee continues as last year, there is not a benefit from a pool bid. If there is a class effect, then there is a benefit. Dr. Brodsky stated that class effect leaves out comments from hospital care providers.

DR. BERGESON MOVED TO DECLARE THIS A CLASS EFFECT AND NOT PREFER TEQUIN. SECONDED BY DR. DEMAIN. DR. BRODSKY CALLED FOR DISCUSSION.

Dr. Demain suggested removing Tequin due to the QT concern. The committee continued discussing the motion and its effect on hospital preferences. They further discussed Levaquin versus Avelox. Dr. Stransky called the question.

WITH NO FURTHER DISCUSSION, CHAIRMAN BRODSKY CALLED FOR A VOTE. MOTION CARRIED WITH DR. HUNT, DR. VON HAFFTEN, MS. BRAINERD AND MS. GALE OPPOSING.

XII. RE-REVIEW OF PEGYLATED INTERFERON ALPHA PRODUCTS AND RIBAVIRINS

Public Comments:

Steve Ichishta, MD, commented on PEG-Intron used for hepatitis C in combination with ribavirin. Depending on genotype, it is used for either 24 or 48 weeks of treatment. It is effective with SVR 50%. It has weight-based dosing. Head to head trial will be done, but he reiterated that SVR is what counts. They do not know which product is superior but he asked for equal access.

Jill Johnson from Laroche testified on Pegasys which is the #1 prescribed drug worldwide. Trials for treatment for post-transplant patients are underway. FDA granted Pegasys priority status in the review of combination therapy. Consistency has been demonstrated regularly. Pegasys is the only agent FDA approved for HIV co-infected patients. Hepatitis B approval was given a few days ago by the FDA. There is one dose for everyone, and it does not reconstitute. She asked that Pegasys be kept preferred.

P&T Committee Discussion:

Ms. Roberts gave information about the pegylated interferon class. Last P&T review agreed agents were equivalent, but they grandfathered in patients on their current therapy. Pegasys was the choice last time. There are about 30 prescriptions per month with 20 for Pegasys.

Dr. Brodsky mentioned that Dr. Sahagun will write "medically necessary" as he gives the most prescriptions and no head to head trials have been done. Dr. Brodsky gave more information about current academic concerns and information about white counts in this patient population. He reiterated that while this is a very treatable disease, it is very difficult to treat in that most patients who begin treatment do not tolerate it or complete it. Success varies according to the viral makeup. Dr. Hunt stated they should both be allowed since there are still questions to be answered.

DR. STRANSKY MOVED TO CONSIDER THIS A CLASS EFFECT. SECONDED BY MS. BRIGGS. DR. BRODSKY CALLED FOR FURTHER DISCUSSION. HEARING NO FURTHER DISCUSSION, DR. BRODSKY CALLED FOR A VOTE. MOTION PASSED UNANIMOUSLY.

XIV. RE-REVIEW OF RIBAVIRINS

Public Comments: There were no comments for this class.

P&T Committee Discussion:

Ms. Roberts presented information about the ribavirins. They were considered equal last time by the P&T committee. Co-Pegas was the selection last time, however. Most data supports the ribavirin being in the same manufacturing group as the interferon.

DR. HUNT MOVED THAT THE RIBAVIRINS BE DECLARED EQUIVALENT WITH A CHOICE OF RIBAVIRIN TO THE INTERFERON CHOSEN. SECONDED BY DR. POLSTON. DR. BRODSKY CALLED FOR DISCUSSION AND AFTER MINIMAL CLARIFICATION, HE CALLED FOR A VOTE. THE MOTION PASSED UNANIMOUSLY.

XV. DISCUSSION OF OTHER BUSINESS

A. Mr. Campana asked Dr. Sater to present the list of changes done in the drug classes since January that will be implemented in July:

- ACE inhibitors – remove remaining brand name drugs with only generic drugs available.
- ACE inhibitor/diuretic combination – Uniretic will go away and the same four drugs with HCTZ.
- Alpha II – Iopidine removed.
- Bisphosphonates – Recommendation and class effect summary resulted in Fosamax as preferred, not Actonel. There is currently 98% compliance. There are currently 1000 prescriptions per month. A letter will be sent out restating the mission of the P&T committee and PDL list and giving information about the change. Dr. Hunt suggested giving a sense of the money saved by the State with this change.
- Inhaled corticosteroids – recommendation from last meeting was for one aqueous preparation and Nasonex; now it will be just Nasonex not Flonase or Nasacort AQ.
- Prostaglandin agonists – Xalatan will be added as preferred agent.
- Short-acting beta agonists – Proventil HFA will be nonpreferred. Generic will be preferred.

B. Mr. Campana informed the committee that Boniva, a bisphosphonate, would not be preferred since it has not been reviewed.

C. The next meeting dates will be: September 16 and October 21, 2005; January 20, February 17, April 21 and May 19, 2005.

D. Mr. Campana expressed his appreciation for the committee and their service to the State.

XVI. REVIEW OF MINUTES

Mr. Campana corrected Melinda's name. Dr. vonHafften asked for clarification about a question asked by Dr. Brodsky to Dr. Woodard, and Dr. Brodsky stated he responded affirmatively.

DR. STRANSKY MOVED TO APPROVE MINUTES. SECONDED BY DR. HUNT. DR. BRODSKY CALLED FOR A VOTE AND THE MINUTES WERE APPROVED UNANIMOUSLY.

The meeting adjourned at 11:10 a.m.